Billing Manual for ICF/MR Facilities

Medical Services
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INTRODUCTION

The purpose of this manual is to outline billing procedures for services provided to individuals eligible for Medical Assistance by ICF/MR facilities.

BASIC BILLING GUIDELINES FOR SUBMITTING ICF/MR CLAIMS

- ICF/MR claims must be submitted to North Dakota Medicaid on paper (UB-92 form) or electronically using the ANSI X12 4010A1 837 Institutional Health Care Claim transaction.

- ICF/MR claims must be submitted to North Dakota Medicaid using a *Bill Type* **213.**

- ICF/MR claims must be submitted to North Dakota Medicaid using the following *Revenue Codes* when billing for:

Revenue Code	*Description*	*Formerly Service Code*
110	In-House Days/ICF for the Mentally Retarded	**T**
120	In-House Days/ICF for the Mentally Retarded – Physically Handicapped	**V**
160	Facility In-House Days/ICF for Mentally Retarded Children	**X**
180	Leave of Absence/ICF for the Mentally Retarded	**U**
184	Leave of Absence/ICF for the Mentally Retarded – Physically Handicapped	**W**

*(Please note: For Dates of Service **Before** 04/01/2004, use Revenue **184**)**

185	Leave of Absence/ICF for the Mentally Retarded – Physically Handicapped	**W**

*(Please note: For Dates of Service 04/01/2004 and **After**, use Revenue **185**)**

189	Leave of Absence/ICF for the Mentally Retarded Children	**Y**

Use of any other Revenue Codes for ICF/MR claims will be invalid and will be returned for correction.

** The National Uniform Billing Committee (NUBC), who maintains the integrity of the UB-92 data set, decided in their November 13-14, 2003 committee meeting to discontinue use of Revenue Code 184 effective **April 1, 2004** due to the lack of use.*

- The rate established for ICF/MR facilities is an all-inclusive rate for routine services. Routine services include supplies, therapies, nursing supplies, equipment, transportation, and non-legend drugs. Separate billings for these items will not be paid.

- Submit ICF/MR charges monthly but DO NOT bill more than one calendar month per claim

INSTRUCTIONS FOR COMPLETING ICF/MR CLAIMS

Listed below are instructions addressing all required fields for submission of ICF/MR claims to North Dakota Medicaid. The **form locators (FL)** for the paper UB-92 claim form are listed below along with explanation of the field. These fields would also be required if the claim is being submitted electronically. For electronic transactions, you would report the required fields that correspond to the appropriate data segment/field in the electronic claim format.

FL1 (PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER):
- Enter the provider name, address and telephone number.

FL3 (PATIENT CONTROL NUMBER):
- (Optional) Enter the patient control number. The number will appear on the remittance advice (RA).

FL4 (TYPE OF BILL):
- Enter the 3-digit type of bill identifying type of facility, bill classification, and frequency. North Dakota Medicaid will require use of **Bill Type 213** for ICF/MR claims.

FL6 (STATEMENT COVERS PERIOD):
- Enter the first date of service and the last date of service for the monthly billing period for this claim. The dates must be continuous. Enter the "From" and "Through" dates of service in MMDDYY format. If the claim covers only one day of service the "From" and "Through" dates must be equal. The "statement covers period" includes the first date of service through the last date of service, which would **include** the actual discharge date, the hospice election date, or date of death, whichever is applicable. ND Medicaid will automatically calculate any non-covered days using the Revenue Code field and Discharge Code field.

FL7 (COVERED DAYS):
- Enter the number of covered days, which would include the actual discharge date, the hospice election date, or date of death, whichever is applicable. The number should equal the statement covers period (FL 6)

FL8 (NON-COVERED DAYS):
- **DO NOT** use this field. ND Medicaid will automatically calculate non-covered days using the Revenue Code field and Discharge Code field.

FL12 (PATIENT NAME):
- Enter the recipient's last name, first name, and middle initial.

FL14 (PATIENT BIRTHDATE):
- Enter the recipient's birth date in MMDDYYYY format.

FL17 (ADMISSION DATE):
- Enter the date of admission in MMDDYY format

FL18 (ADMISSION HOUR):
- Enter the hour of admission (00-23). If unknown, enter **00**. (This field is required)

FL19 (TYPE OF ADMISSION):
- Enter the type of admission code. (This field is required) <u>Please note</u>: Type of Admission code **9** is <u>invalid</u>. If unknown, enter **3**.

1	Emergency
2	Urgent
3	Elective
4	Newborn

FL20 (SOURCE OF ADMISSION):
- Enter the source of admission code. If unknown, enter **9**

1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available

FL21 (DISCHARGE HOUR):
- Enter the hour of discharge (00-23). If unknown, enter **00**.

FL22 (DISCHARGE/STATUS CODE):
- Enter the patient status code. Whenever a recipient is discharged from the ICF/MR facility, a code must be entered in this block. Refer to the National Uniform Billing Data Element Specifications UB-92 manual for the appropriate discharge codes or the list below. If a recipient is still a resident in your facility at the time you submit a monthly billing, use discharge code **30**.

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification
04	Discharged/transferred to intermediate care facility (ICF)
05	Discharged/transferred to another type of institution for inpatient care
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home care under care of Home IV provider
09	Admitted as an inpatient to this hospital
20	Expired
30	Still a patient
40	Expired at home
41	Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice)
42	Expired – place unknown
43	Discharged/transferred to a federal hospital

50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to hospital-based Medicare approved swing bed
62	Discharged/transferred to another rehabilitation facility including rehabilitation distinct parts units of a hospital.
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.

FL42 (REVENUE CODE):

- Enter appropriate revenue codes for services provided. List all revenue codes in ascending *Service Date* order (**FL45**), followed by **001** for the Total Charge Line. North Dakota Medicaid will require use of the following Revenue Codes:

  Revenue Code **110** for In-House Days/ICF for the Mentally Retarded

  Revenue Code **120** for In-House Days/ICF for the Mentally Retarded – Physically Handicapped

  Revenue Code **160** for Facility In-House Days/ICF for Mentally Retarded – Children

  Revenue Code **180** for Leave of Absence/ICF for the Mentally Retarded

  Revenue Code **184** for Leave of Absence/ICF for the Mentally Retarded – Physically Handicapped
  *(Please note: For Dates of Service **Before** 04/01/2004 use Revenue **184**)*

  Revenue Code **185** for Leave of Absence/ICF for the Mentally Retarded – Physically Handicapped
  *(Please note: For Dates of Service 04/01/2004 and **After**, use Revenue **185**)*

  Revenue Code **189** for Leave of Absence/ICF for the Mentally Retarded – Children

  Please note: You **must** enter Revenue Codes for charges in Service Date order or the claim will reject. (Example: Revenue Code **185** for DOS 07/01/04 – 07/04/04 would be billed *before* Revenue Code **120** for DOS 07/05/04 – 07/31/04) on your claim.

  Use of any other Revenue Codes for ICF/MR claims will be invalid and will be returned for correction.

FL43 (REVENUE DESCRIPTION):

- (Optional) Enter the revenue description.

FL44 (HCPCS/RATES):

- You **must** enter your ICF/MR all-inclusive rate in this space or the claim will be rejected

FL45 (SERVICE DATE):

- You **must** enter the first date of service for the specific Revenue code you are billing on that line item. If you do not enter the first date of service in this field, the claim will be rejected.

FL46 (UNITS OF SERVICE):
- Enter the units of service applicable to each revenue code billed. The total number of units for all revenue codes billed on the claim should equal the statement covers period (FL 6), and should equal the covered days (FL 7).

FL47 (TOTAL CHARGES):
- Enter the total charges for each revenue code billed in this column.

FL51 (PROVIDER NUMBER):
- Enter the North Dakota Medicaid Provider Number (308XX) that has been assigned to you for ICF/MR services. If the incorrect provider number is used, denial of payment will result.

FL54 (PRIOR PAYMENTS):
- Enter payments from other payers corresponding to the payers listed in FL50 A, B, and C, if applicable. If a recipient receives proceeds from an insurance policy that covers ICF/MR services, enter the appropriate amount that applies to the total charges billed on each authorization. The amount must be subtracted from FL 47. Do not enter prior NDMA payments or Recipient Liability amounts.

FL55 (ESTIMATED AMOUNT DUE):
- Enter the difference between the **Total Charges** and the **Prior Payments** (FL54). It is always required to make an entry in this block. Therefore, if there is not an entry in Prior Payments (FL54) it is required that the total charges be shown in field locator 55 (Estimated Amount Due). A claim for a Medicaid recipient must be submitted for each month the individual is in the ICF/MR even if the balance due is zero after insurance payments. Other Medicaid providers cannot be paid until the ICF/MR claim is processed.

FL58 (INSURED'S NAME):
- Enter recipient's last name, first name, and middle initial.

FL60 (RECIPIENT IDENTIFICATION NUMBER):
- Enter the recipient's 9-digit North Dakota Medicaid ID number. **DO NOT** use the recipient's social security number.

FL67 (PRINCIPAL DIAGNOSIS CODE):
- Enter the principal diagnosis code from the ICD-9-CM (**DO NOT** enter decimal point). It is necessary to include at least one diagnosis code.

FL85 (PROVIDER REPRESENTATIVE SIGNATURE):
- This block must be dated and signed by the designated employee who has the responsibility to obligate the facility to the stipulations contained in this block. The signature may be typed, stamped, or handwritten.

FL86 (DATE BILL SUBMITTED):
- Enter the submission date in MMDDYY format.